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Making and Communicating Decisions about Sexual Consent during Drug-Involved Sex: A Thematic Synthesis

Abstract

Sexual consent is a central component in the primary prevention of sexual violence. There is growing evidence of the impact that alcohol consumption has on sexual consent. However, there has been no review examining sexual consent in the context of other drug-taking. Published literature was sought using searches of: PsycINFO, PsycARTICLES, Scopus, Web of Science, CINAHL, MEDLINE and Open Dissertations. Unpublished literature, such as, unpublished government or charity reports, were identified through Google search engine. All 21 eligible studies employed qualitative or mixed methods therefore a thematic synthesis was deemed an appropriate method of analysis. Three themes were constructed: 'Drug-taking changes sexual norms', 'Drug-taking diminishes the capacity to make sexual decisions' and 'Drug-taking reduces verbal and non-verbal ability to communicate consent'. The findings demonstrated that prevailing models of sexual consent may not account for circumstances relevant to drug-involved sex, such as how drug-taking impacts freedom and capacity to consent to sex. We propose the use of the medical model of capacity to consent as a broader framework through which capacity to consent to sex in drug-taking contexts can be assessed. The importance of both the social and situational context for sexual decision-making following drug-taking is discussed.

Sexual violence involves ‘causing a person to engage in sexual activity without consent’ (Sexual Offences Act, 2003; Part 1, Section 4). This can include (but is not limited to), instances of sexual harassment, sexual coercion, sexual assault, and rape (see WHO, 2013). Sexual violence remains a global public health problem (World Health Organization; WHO; 2013). Historically, sexual violence researchers and those working towards sexual violence prevention have employed criminal justice-based approaches to address sexual violence perpetration and victimization. They have focused on who is ‘at-risk’, the context in which sexual violence takes place, and its personal, social, and economical consequences (McMahon, 2000). This research has been beneficial to both secondary (e.g., focusing on ‘at-risk’ groups) and tertiary (e.g., reducing recidivism) prevention (Smallbone et al., 2008). In contrast, the public health approach to sexual violence, which is now favored by many scholars involved in prevention work, emphasizes primary prevention (Shields & Feder, 2016). That is, strategies focused on preventing sexual violence in the first instance. Sexual consent, such as how it is conceptualized, understood and communicated, is therefore a central component in the primary prevention of sexual violence and represents the focus of this review (Borges, Banyard & Moynihan, 2008).

As noted by Muehlenhard, Humphreys, Jozkowski and Peterson (2016), sexual consent has been conceptualized in many ways by researchers. These conceptualizations have included, an internal feeling of willingness, an explicit agreement to have sex (e.g., verbal and non-verbal behaviors used to communicate one’s own willingness), and the behaviors, cues, or signals, that a person uses to interpret someone else’s willingness (e.g., the steps taken to determine another person’s consent). The most commonly used definition of sexual consent incorporates a number of these elements, describing it as, “the freely given verbal or non-verbal communication of a feeling of willingness”, to have sex (Hickman &

Muehlenhard, 1999; p.3). According to the authors of this definition, willingness is synonymous with consent and wantedness is synonymous with desire; whilst these constructs may often be related, consent is distinct from wanting. That is, people can consent to sex when they do or do not want it (Peterson & Muehlenhard, 2007).

Affirmative consent standards are the prevailing model for sexual consent education and policy; individuals are required to gain conscious, voluntary, and often verbal consent at every stage of a sexual experience (Jozkowski, 2015; Tinkler, Clay-Warner & Alinor, 2018). Unsurprisingly then, a broad range of sexual consent research has focused on the particulars of consent communication (e.g., Beres, Herald & Maitland, 2002; Jozkowski & Peterson, 2013). There is wide consensus that the non-verbal expression of sexual consent, such as, touching or reciprocating sexual advances, is the most common way that people determine consent (Beres, 2010; Jozkowski et al., 2014). Although, both personal and situational factors, such as, gender, the nature of the relationship, the ‘type’ of sexual act (Humphreys, 2004; 2007; Willis & Jozkowski, 2019) and whether alcohol was consumed (Jozkowski & Wiersma, 2015), play influential roles.

Affirmative consent models have helped to advance both sexual consent education and policy (Tinkler, Clay-Warner & Alinor, 2018). Yet, these models do not fully address every facet of sexual consent, such as, the factors that impact the autonomous and freely given aspects of consenting to sex. Determining whether a person is making a choice freely and that they understand what that choice means, arguably precedes their ability to communicate it. For example, if a person lacked awareness of what was taking place then whether they communicated a ‘yes’ is arguably irrelevant (see Sexual Offences Act, 2003). Substance use is one factor that may have delimiting effects on the autonomous aspect of consent (Palmer, 2013). This is because alcohol and other drugs can diminish cognitive capabilities, such as, working memory and executive functions (Degenhardt & Hall, 2012).

Furthermore, some classes of drugs, such as analgesic drugs, can impair the motor functions necessary to communicate decisions (e.g., ketamine; Muetzelfeldt, Kamoj, Rees, Taylor, Morgan & Curran, 2008). Despite alcohol and other drugs having these effects, not all sex that takes place following substance use is conceptualized as non-consensual. For example, people report ostensibly consensual sex following alcohol consumption (Jozkowski & Wiersma, 2015). This is evident even where people have reported a diminished capacity to consent at the time, such as, being unable to remember what had taken place the next day (Coleman & Cater, 2005; Vagenas et al., 2017).

Although substance-involved sex may sometimes be considered consensual to the people who engage in it, alcohol consumption is implicated in many instances of sexual violence (up to 50%; Abbey, Zawacki, Buck, Clinton, & MacAuslan, 2004). It is therefore unsurprising that researchers have examined sexual consent in the context of alcohol use; the findings of which have been influential to alcohol-focused sexual violence primary prevention strategies (e.g., Carline, Gunby & Taylor, 2017).

People's internal feelings of consent and how that consent is expressed, may be changed through alcohol consumption. Jozkowski, Sanders, Peterson, Dennis & Reece (2014) suggested that there are many internal feelings that an individual might interpret as willingness, such as, physical responses (e.g., rapid heartbeat, erect penis), arousal (e.g., 'interested', 'turned on', 'aroused'), and feelings of safety and comfort, wantedness, and readiness. These feelings related to consent might then be communicated in a variety of ways, such as through non-verbal behaviors (e.g., body language), passive behaviors (e.g., not saying 'no', lack of resistance, 'letting' sexual activity happen), sexual communication or initiation (e.g., used verbal cues such as asking a partner, initiated behavior to see if a partner communicated), 'borderline pressure' to gain someone else's consent (e.g., shutting a door) or no response (e.g., because it was obvious). In a subsequent study, Jozkowski and Wiersma

(2015) found that people who drank alcohol prior to consensual sex, reported reduced feelings of safety and comfort, and readiness, during consensual sex, and used fewer sexual communication or initiation and non-verbal behaviors to communicate their consent, compared to people who did not consume alcohol.

Alcohol consumption also influences how consent is determined by others (Muehlenhard et al., 2016). Muehlenhard et al.,’s (2016) review of the literature surrounding sexual consent and college students demonstrated that people can perceive others to be ‘sexually available’ following alcohol consumption. Furthermore, this appeared to be a gendered relationship, such that, men perceived women as having more sexual intent when they had consumed alcohol. When men have also consumed alcohol, this relationship appears to be strengthened (see Abbey, Buck, Zawacki & Sanes, 2003; Abbey, Zawacki & Buck, 2005). More recent research has extended this finding by demonstrating that both women and men view women’s alcohol consumption and their acceptance of alcohol, such as from a man for ‘free’, as a consent ‘cue’ (Jozkowski, Manning & Hunt, 2018).

Many individuals hold positive expectancies for the effect of alcohol on sex, such as sexual desire and sexual arousal being heightened following alcohol use (Lefkowitz, Waterman, Morgan, & Maggs, 2016). These beliefs are often perpetuated in locations where alcohol is consumed (e.g., bars and clubs; Phipps & Young, 2015). When sexual desire is perceived to be heightened following alcohol consumption, individuals may assume the consent of people who are drinking. For example, they may not take the necessary steps towards confirming another person’s willingness. In locations typically associated with alcohol consumption, this may be more frequent. Previous research has found that young men feel entitled to initiate sexual contact in nightclub settings in ways that they do not deem acceptable in other spaces (Thompson & Cracco, 2008).

People voluntarily consume drugs other than alcohol prior to having sex; however, the exact prevalence of people who do so is unclear (Desai, Bourne, Hope & Halkitis, 2018).

‘Drugs’ refer to substances with psychoactive properties. Though, for the purposes of this review, we will use the term ‘drugs’ to refer to substances other than alcohol, nicotine, and caffeine, including any illicit drug and non-medical use of prescription drugs. Like broader trends of illicit drug use, cannabis and 3,4 methylene-dioxymethamphetamine (MDMA; ecstasy) are the most commonly reported drugs consumed prior to sex (Lawn, Aldridge, Xia & Winstock, 2019). However, people’s gender and sexual orientation may account for some of the differences in the specific drugs that individuals are likely to have ever ‘had sex’ on. Men who have sex with men, for example, are more likely to have ever had sex following gamma-hydroxybutyrate (GHB) compared with their heterosexual counterparts (Lawn et al., 2019). To date, there has been no review on people’s experiences of sexual consent in the context of drugs.

It is possible that different drugs differentially impact the facets of sexual consent as a result of their wide-ranging psychoactive effects. Drugs with anesthetic properties, such as, GHB and ketamine can result in drowsiness, loss of consciousness, and dissociation (Jansen, 1993; Oliveto et al., 2010). MDMA, has been found to impair concentration and short-term memory (Britt & McCance-Katz, 2005). It is likely that these effects can impact a person’s ability to retain information pertinent to making a sexual decision, or impact how that decision is communicated. Furthermore, people have been found to hold positive sex-related expectancies for many illicit drugs. These include that they enhance sexual desire, arousal and libido (Sumnall, Beynon, Conchie & Cole, 2007). It is possible that a similar association to that of alcohol and sexual consent exists, such that, individuals are perceived as having more sexual intent when they are consuming drugs.

Understanding how individuals conceptualize and practice sexual consent in drug-taking scenarios may inform future recommendations concerning sexual consent education, as well as harm-reduction approaches for individuals that use drugs in sexual contexts. Given the evidence that different subgroups are more likely to consume certain drugs prior to sex than others (Lawn et al., 2019), understanding what consent looks like across the broad range of drugs that people consume (e.g., cannabis, ecstasy, cocaine, ketamine) is important for tailored harm-reduction initiatives.

Summary

Sexual consent is a central component in the primary prevention of sexual violence. To date, much research has focused on how individuals communicate consent during sober and alcohol-involved sexual scenarios (e.g., verbally / non-verbally). Despite evidence that individuals consume both alcohol and other drugs prior to sex, and thus, sexual consent being relevant to each of these, research efforts have primarily focused on alcohol. Alcohol has been shown to impact internal feelings related to consent, the cues that people use to communicate that consent, and how consent is interpreted by others. To date, there has been no review of the literature to examine these areas in the context of drugs. Research has also failed to account for other facets of sexual consent relevant to substance using scenarios, such as, what it means to have the freedom and capacity to consent to sex in the first place. In order to develop effective harm-reduction and consent education tailored to individuals that use drugs in sexual contexts, we must address the topic across the broad range of drugs that people use prior to sex. As such, this systematic review aimed to examine the literature on people's attitudes towards or experiences of: (a) willingness to have a sexual experience following the voluntary consumption of drugs; (b) the freedom and capacity to give/gain sexual consent following the voluntary consumption of drugs; (c) determining,

communicating or negotiating sexual willingness, following the voluntary consumption of drugs.

Methods

Inclusion and Exclusion Criteria

To be included in the review, an article had to report findings related to at least one area of the review question. Furthermore, one or more adults must have voluntarily consumed (or be perceived to have used) a drug at the time of/ prior to the sexual activity or reported being under the influence of drugs at the time. We limited our review to instances in which individuals voluntarily consumed drugs. In cases of covert or forced administration the individual(s) would have already been violated by the other person. Articles were only included if drugs were reported as consumed either on their own or in combination with alcohol. Where research examined alcohol consumed on its own, or where it was unclear whether other drugs had been consumed, the study was excluded. This is because we were interested in other drug contributions specifically.

Adopting prevailing definitions of consent, such as Hickman and Muehlenhard's (1999) definition, "the freely given verbal or non-verbal communication of a feeling of willingness" to have sex (p.3), may be problematic in drug-taking contexts. This is because substance use can have delimiting effects on the autonomous aspect of consent (i.e., 'freely given'; Palmer, 2013), although the individual might still perceive such experiences to be consensual (e.g., Jozkowski & Wiersma, 2015). For the purposes of this review, we included articles based on whether the data focused on a feeling of willingness (rather than unwillingness) to have sex. Whilst we recognize that sexual consent contains components in addition to willingness (i.e., the freedom and capacity to make decisions and ability to communicate them), these issues are not yet fully understood in relation to drug-involved sex.

Consequently, no article was excluded based on a lack of freedom or capacity, and these issues were explored in relation to drug-involved sex as part of the review.

If an article reported on both consensual and non-consensual sex (i.e., sex involving feelings of willingness and sex involving feelings of unwillingness), it was included but only the findings related to consensual sex were analyzed. Studies examining only non-consensual sex were excluded. As highlighted in the introduction, this review takes a public health approach to sexual violence, which emphasizes primary prevention. Thus, identifying articles which focused on sexual consent or contained information relevant to consensual as opposed to non-consensual sexual experiences was deemed appropriate. Articles that reported only findings related to sexual wantedness were also excluded. As outlined earlier, consent and wantedness are not synonymous. It is possible for individuals to want sex that they do or do not consent to (Peterson & Muehlenhard, 2007). For example, a person may want to engage in a sexual experience but not consent to it due to a lack of contraception.

If data were collected from participants below the age of 16 (the legal age of consent in the United Kingdom), the article was not an empirical study, or was not written in the English language it was excluded. Where multiple articles reported on the same cohort and met the inclusion criteria, the paper with the greatest amount of data on sexual consent following drug-taking was included.

Search Strategy and Study Selection

All empirical research was eligible, including (but not limited to): longitudinal, cross-sectional, cross-sequential and quasi/ experimental designs producing qualitative, quantitative or mixed methods data. Articles could be peer-reviewed journal articles, dissertations, grey literature, or book chapters, which included original research. Grey literature refers to

research produced by organizations outside of the typical academic publishing process and has not undergone the academic peer-review process (e.g., government or charity reports).

Peer-reviewed articles, book chapters and dissertations, written in the English language, were identified using searches of: PsycINFO, PsycARTICLES, Scopus, Web of Science, CINAHL, MEDLINE and Open Dissertations. Grey literature was identified using Google search engine (all search returns on a page were examined until all returns on a page did not meet the inclusion / exclusion criteria). Searches were carried out August – September 2018. No date limitations were enforced. The reference lists of included articles were examined for further relevant articles.

Compared to other sexuality-related topics, such as sexual health or violence, sexual consent research is limited. Therefore, in order to capture a range of sexuality-related topics, the search strategy was designed for breadth not specificity. Keywords, as opposed to MeSH/subject heading searches were used; MeSH heading searches are less flexible and are not always up-to-date with recent concepts (Park, 2003). The search terms employed were developed through expanding the areas of sexual consent, sexual practices and drug-taking (see Table 1 for search terms).

[insert Table 1 near here]

Titles and abstracts of articles produced by the search string were assessed against the inclusion and exclusion criteria. Where eligibility was unclear, the full-text was examined. The criteria were then reapplied to each full-text to confirm that identified articles were eligible. A research assistant (MH) independently reviewed a random sample of 10% of included ($n = 2$) and excluded ($n = 13$) studies against the eligibility criteria.

Data Extraction and Study Quality

The primary author (LS) developed a data-charting form. Information on the study, including aims, design, country, study setting, recruitment strategy, data analysis, participant characteristics, drugs of interest, and funding source were extracted (study findings were addressed differently – see ‘Thematic Synthesis’).

Quality appraisal of qualitative papers took place using the Critical Appraisal Skills Programme tool (CASP; 2018). The Mixed Methods Appraisal Tool (MMAT; Hong et al., 2018) was employed for mixed methods articles. If an article reported only the methods pertaining to the qualitative data from a larger mixed-methods study, the CASP was implemented. This is because there would not be enough information to judge the mixed methods component. These tools were implemented irrespective of whether a paper was a peer-reviewed journal article or grey literature. Neither measure recommends excluding articles based on study quality. Therefore, no study was excluded because of quality. Instead, in line with author recommendations for the MMAT, the quality assessment for each category relevant to the study design (e.g., qualitative, quantitative and mixed methods) for each mixed methods article is presented as online supplementary material to this paper (see supplementary material Table 1; Hong et al., 2018). Similarly, the total CASP score is presented as supplementary material for each qualitative article (see supplementary material Table 2). Key limitations pertaining to the quality of the included papers are highlighted in the ‘Limitations of Included Studies’ section. No quantitative papers were identified by the searches; thus, no appraisal tool was required for papers using quantitative methods.

Data extraction and quality assessment took place simultaneously. LS extracted the data from all included articles and a research assistant (ZW) independently extracted data from 20% of the included articles ($n = 4$). LS appraised the quality of all included studies. Independently, ZW and MH each assessed the quality of 10% of the articles. A total of 20%

($n = 4$) of the studies were appraised by multiple reviewers (Schlosser, 2007). Any differences were discussed and resolved.

Thematic Synthesis

The analysis involved a thematic synthesis and was guided by the methodological framework proposed by Thomas and Harden (2008). Since all studies meeting the criteria used qualitative or mixed methods, thematic synthesis was deemed appropriate (Thomas & Harden, 2008). Rather than describing past research findings (e.g., a textual narrative synthesis), thematic synthesis involves reinterpreting the findings from primary studies to go beyond the original data content (Barnett-Page & Thomas, 2009). Thematic synthesis allows for the synthesis of findings from research utilizing a range of different methods (Thomas & Harden, 2008).

Prior to analysis, the 'Findings/Results' section of the included papers were entered verbatim into NVivo. The primary author undertook the thematic synthesis in three steps. Firstly, line-by-line coding of the primary (i.e., participant quotes) and secondary (i.e., authors' interpretations) data was undertaken. At this stage the data were examined for content and meaning. Step two involved the development of descriptive themes (i.e., that reflected the original content of the data). This involved organizing codes into meaningful and related categories. The final stage involved the development of analytical themes. At this point, similar descriptive themes were grouped to create higher-level constructs; the focus at this stage was to reinterpret findings from the original studies considering the review topic (see Table 2 for theme development process; Thomas & Harden, 2008). Through discussion with MH and discussion between the authors of this review, the themes were finalized.

[insert Table 2 near here]

Historically, researchers have undertaken (and subsequently reported) interrater reliability at the point of coding qualitative data to increase the transparency and perceived reliability of their research (Belur, Tompson & Simon, 2018). However, this method is rooted in a realist position that posits that a knowable reality exists and can be directly measured. In contrast to a realist position, critical realism argues that reality cannot be directly measured because we always interpret reality in view of our own historical, social, political and cultural positioning (Scott, 2005). Therefore, if there is high interrater reliability, this is likely because one coder has been trained into interpreting reality in the same way as another coder (i.e., to apply a similar ‘worldview’; Joffe & Yardley, 2003). Within critical realism, multiple perspectives on reality are recognised and are seen as a strength that enables us to have a fuller understanding of the data. In line with this, the first author (LS) read the Findings/Results sections of all included papers and coded the data, then a research assistant (MH) read the Findings/Results sections of the included papers and made notes, and LS and MH subsequently discussed their interpretations of the data together. Lastly, a write-up of the analysis was discussed with the second and third authors. In this way, the analysis considered multiple perspectives on the data to arguably produce a more complete analysis of the data. Some researchers refer to this process as ‘investigator triangulation’ (Flick, 2004); a similar approach has been adopted in other systematic reviews as an alternative to interrater reliability (e.g., Chong et al., 2016).

Results

The searches produced 19,751 unique articles. Most were not eligible during first-stage screening because the title or abstract did not meet our inclusion criteria (N = 19,624). For example, if it was clear that a paper focused on drug-taking and sexual aggression but did not examine consensual sex, it was excluded at this stage. If it was unclear whether this was the case, the full text of the article was examined. Of the 127 papers screened at the second

stage, 100 were excluded (see Figure 1 for exclusion reasons); 27 individual papers that represented 21 studies (i.e., contained the same cohort) met the inclusion criteria. Following the decision to include articles containing the most relevant information, the final sample constituted 21 papers.

[insert Figure 1 near here]

Included articles were published from 2003 – 2018. Two articles were unpublished research reports, 19 were peer-reviewed journal articles (See Table 3 for study sample characteristics). The studies were undertaken across a range of continents: North America (USA; $n = 11$; Canada; $n = 1$); Europe (United Kingdom; $n = 3$; Republic of Ireland; $n = 1$; Sweden $n = 1$; Germany; $n = 1$); Asia (China; $n = 1$; Malaysia $n = 1$) and Australasia (Australia; $n = 1$). The total number of participants across the included studies was 1323 (range: 14 – 322). Their ages ranged from 18 – 59 years. Almost half of the studies were undertaken with men only, seven studies recruited both men and women, and four studies recruited women only. Nine studies were undertaken with men who had sex with other men (e.g., gay or bisexual), five studies included people who identified as heterosexual/straight and homosexual/lesbian, gay or bisexual+, and three studies included people who identified as heterosexual/straight only. In four studies the sexual orientation of the sample was unclear. Most studies reported employing opportunity sampling ($n = 13$). Others reported using: snowball sampling ($n = 7$); time-space sampling ($n = 1$); purposive sampling ($n = 1$); ‘seed’ sampling ($n = 1$); stratified sampling ($n = 1$), or; respondent-driven sampling ($n = 1$). The specific recruitment platforms included, bars/clubs/sex-on-premises venues ($n = 5$), sexual health clinics ($n = 4$), drug services (e.g., treatment centres/outreach services; $n = 4$), online (e.g., social networking apps, Facebook; $n = 4$), service providers (e.g., AIDS support groups; $n = 4$), print magazines ($n = 2$), universities ($n = 2$), coffeehouses ($n = 1$) and other locations deemed relevant to the target populations (e.g., high street stores; $n = 2$).

Ten articles focused on a specific drug: methamphetamine ($n = 5$), MDMA ($n = 3$), mephedrone ($n = 1$) opioids ($n = 1$), or cannabis (in comparison to alcohol; $n = 1$). The rest focused upon multiple drugs such as ‘club drugs’, which included cocaine, MDMA, ketamine and amyl nitrate; or ‘Chemsex’ drugs, which included methamphetamine, mephedrone and GHB. Several studies also included alcohol consumption.

Mixed ($n = 4$) and qualitative ($n = 17$) methods were used. Data analysis methods included thematic analysis, narrative methods, interpretative phenomenological analysis, qualitative content analysis, grounded theory and mixed methods.

[insert Table 3 near here]

Findings

Three themes were constructed from the data. The first theme indicated that drug-taking changes a person’s sexual norms (Bourne, Reid, Hickson, Torres-Rueda & Weatherburn, 2014; Deimel, Stöver, Höbelbarth, Dicht, Graf & Gebhardt, 2016; Eiserman, Diamond & Schmense, 2008; El-bassel, Gilbert & Rajah, 2003; Green & Halkitis, 2006; Jerome, Halkitis & Siconolfi, 2009; Jessell, Mateu-Gelabert, Guarino, Vakharia, Sykes, Goodbody & Friedman, 2017; Lim, Akbar, Wickersham, Kamarulzaman & Altice, 2018; Liu & Chai, 2018; Lorvick, Bourgois, Wenger, Arreola, Lutnick, Wechsberg & Krala, 2012; McElrath, 2005; Mullens, Young, Hamernik & Dunne, 2009; Palamar, Acosta, Ompad & Friedman, 2018; Palamar, Kiang, Storholm & Halkitis, 2014; Skärner & Svensson, 2013; Van Hout, & Brennan, 2011). This theme contained two subthemes: (a) acute drug-taking increases a person’s perceived sexual autonomy, and, (b) people who consume drugs are perceived as ‘sexually available’. The second theme indicated that drug-taking can diminish a person’s capacity to make sexual decisions (Bauermeister, 2007; Bourne, Reid, Hickson, Torres-Rueda & Weatherburn, 2014; Deimel, Stöver, Höbelbarth, Dicht, Graf & Gebhardt,

2016; Eiserman, Diamond & Schmense, 2008; Harvey, Hayton, Beard & Holly, 2013; Kennedy, Grov & Parsons, 2010; Lim, Akbar, Wickersham, Kamarulzaman & Altice, 2018; Liu & Chai, 2018; Lorvick, Bourgois, Wenger, Arreola, Lutnick, Wechsberg & Krala, 2012; McElrath, 2005; Mullens, Young, Hamernik & Dunne, 2009; O’Byrne & Holmes, 2011; Palamar, Acosta, Ompad & Friedman, 2018; Palamar, Kiang, Storholm & Halkitis, 2014; Pass, Younge, Geter, Al-Bayan & Wade, 2015; Van Hout, & Brennan, 2011) and the third theme indicated that drug-taking reduces a person’s verbal and non-verbal ability to communicate consent after drug-taking (Bourne, Reid, Hickson, Torres-Rueda & Weatherburn, 2014; Deimel, Stöver, Hößelbarth, Dicht, Graf & Gebhardt, 2016; El-bassell, Gilbert & Rajah, 2003; Jerome, Halkitis & Siconolfi, 2009; Lim, Akbar, Wickersham, Kamarulzaman & Altice, 2018; McElrath, 2005; Mullens, Young, Hamernik & Dunne, 2009; Palamar, Acosta, Ompad & Friedman, 2018; Palamar, Kiang, Storholm & Halkitis, 2014; Skärner & Svensson, 2013). The findings pertaining to each of these themes are presented below.

Drug-taking Changes Sexual Norms

Acute drug-taking increases perceived sexual autonomy.

Drug-taking increased people’s sense of being able and willing to express themselves sexually. Drug-taking could be a purposeful activity that enabled people to overcome barriers that prevented sexual engagement. These barriers included: low self-esteem; guilt about sexual practices; concerns due to religious beliefs; social rules, and; beliefs about same-sex sexual behavior. One man stated, “He [his boyfriend] can’t get fucked without it. He’s totally Catholic-guilty, and I have to drug him to have sex with him, which he loves” (Palamar et al., 2014, p.152). The authors from another study concluded that, “For some of the men, the identity-masking effect of the high means that they dared try same-sex sex, which was

otherwise a taboo for them” (Skårner & Svensson, 2013, p.411). These data suggest that people may be more likely to consent to sex that is desired following drug-taking due to a reduction in cognitive concerns that otherwise inhibit sex taking place.

Drug-taking facilitated people’s willingness to engage in different types of sex (Bourne et., 2014; Deimel et al., 2016; Eiserman, Diamond & Schmensul, 2008; Green & Halkitis, 2006; Jerome, Halkitis & Siconolfi, 2009; Liu & Chai, 2018; Palamar et al., 2018; Palamar et al., 2014; Skårner & Svensson, 2013; Van Hout & Brennan, 2011). This included sex that was previously undesired or unimagined. One author concluded, “...inhibitions are broken down and sometimes they allow practices that they would not allow when sober” (Deimel et al., 2016, p.6). Furthermore, following drug-taking, people described being more willing to take initiative, have group sex, engage in bondage and discipline/dominance and submission/sadism and masochism (BDSM), use sex toys, try new sexual positions, role-play and act out sexual fantasies, compared to when sober. One woman participant described how sex on drugs increased her and her partner’s willingness to engage in new types of sober sex too, “We find a lot of the time the things we do when we are high...can spill into our sober sex life... the Meph opened doors...” (Van Hout & Brennan, 2012, p.96). For other people, a willingness to engage in desired sex was only obtainable following drug-taking, “I would also like to regularly have the kind of sex that I imagine. And I need drugs for that” (Deimel et al., 2016, p.6). These findings suggest that some people are willing to extend their sexual boundaries or limitations following episodes of sex on drugs whereas other people may only consent to having sex that they desire when they are intoxicated.

Drugs also appeared to increase people’s willingness to have undesired sex. That is, consent to sex that they did not desire at the time (Green & Halkitis, 2005; O’Byrne & Holmes, 2013; Skårner & Svensson, 2013). One woman participant, described how her partner enjoyed sex when she had consumed drugs because of her increased willingness to

have anal sex with him, “He loved it when I was high because I’d be so... we had sex in a way that I didn’t really want to have sex. Like, I don’t like anal sex, but when I’m high I can do it” (Skårner & Svensson, 2013, p.415). Given that drug-taking can impact sensory experience (Duff, 2008) – such as enhanced touch or decreased pain – people may be more willing and subsequently consent to engage in sexual behaviors that they otherwise would not following drug use or use specific drugs to increase their feelings of willingness to engage in specific sexual acts. For example, ketamine reportedly made anal sexual practices more comfortable (Bourne et al., 2014; Deimel et al., 2016; Palamar, Kiang, Storholm & Halkitis, 2015). Methamphetamine, reportedly increased some men’s willingness to engage in ‘rougher’ sex, “... when I’m on that stuff, I have been beaten, knocked unconscious... what this drug does to me as far as sex goes and what I allow myself to do and be done to me is just, I just could not endure without it, without being on it” (Jerome, Halkitis & Siconolfi, 2009, p.326); the phrase, “what I allow myself to do and be done to me” suggests that, despite the degree of force and lack of consciousness, the participant considered these experiences to be consensual.

Drugs were not only related to an increase in willingness to engage in desired sex, undesired sex, and particular types of sex, but they were also related to an increase in willingness to engage in sex with a wider range of sexual partners. Heightened emotional connection, such as feeling more loving, was discussed in relation to MDMA, cannabis and heroin (El-bassell, Gilbert & Rajah, 2003; Kennedy, Grov & Parsons, 2010; McElrath, 2005; Palamar et al., 2018; Palamar et al., 2014; Mullens et al., 2009). Similarly, an increased sense of intimacy, connectedness or trust was discussed in relation to amyl nitrate, cannabis, opioids, crystal methamphetamine and mephedrone (Bourne et., 2014; Van Hout & Brennan, 2012; Green & Halkitis, 2006; Jessell et al., 2015; Palamar, Acosta, Ompad & Friedman, 2018; Mullens, Young, Hamernik & Dunne, 2009). Experiencing a heightened emotional

connection due to drug-taking may increase people's feelings of willingness to have sexual contact with people that they otherwise would not, as one participant explains, "...you let your guard down and have sexual contact with someone you wouldn't ordinarily have sex with" (Mullens, Young, Hamernik & Dunne, 2009, p.145). However, one participant highlighted that this sometimes resulted in feelings of regret, "It's not usually what you did, it's usually who you did it with. . ." (O'Byrne & Holmes, 2011, p.1516). It is possible that once the effects of the drugs have subsided, individuals no longer feel emotionally connected to their sexual partner(s). Bourne et al. (2014) described how participants were aware of the disingenuous nature of emotional connections once the effects of drugs diminished, "men with whom they shared an intense, cognitively-connected, sexual experience could appear cold or distant when the effects of the drugs wore off" (p.144). Experiencing a heightened emotional bond to another person may also result in increased feelings of willingness to change their sexual health practices. For example, when experiencing an increased trust toward a partner people may be more willing to participate in condomless sex. Condomless sex has found to be symbolic of intimacy and trust (Fortenberry, 2018) and this was evidenced by one participant who stated, "...Ecstasy increased the likelihood of unprotected sex, not because of increased sexual desire but because 'you want to be a romantic fuck'" (McElrath, 2005, p.1472).

People who consume drugs are perceived as 'sexually available'.

People who consumed a range of drugs described that they were perceived as sexually available by people within and outside of their drug-taking communities. This perception appeared to be related to two underlying assumptions. First, that people are easier to convince to have sex when they have consumed drugs. Second, that people who consume drugs will exchange sex for drugs.

Drug-taking was frequently associated with a heightened wantedness for sex (Bourne et al., 2014; Van Hout & Brennan, 2011; El-bassell, Gilbert & Rajah, 2003; Green & Halkitis, 2006; Lim et al., 2018; Liu & Chai, 2018; Lorvick et al., 2012; Palamar et al., 2014; Skårner & Svensson, 2013; Eiserman, Diamond & Schmenseul, 2008; Mullens et al., 2009). This may explain why some men held the belief that it was easier to obtain consent from women consuming drugs (Eiserman, Diamond & Schmenseul, 2008; Skårner & Svensson, 2013). One man stated, “Of course it’s easier if you meet a girl who’s also doing it. Then you think...she’s just as horny. Then it’s easier to get her into bed” (Skårner & Svensson, 2013, p.409). It could also explain why some women held the perception that they were “at risk” of sexual advances from men when they were high/intoxicated. One woman told, “...It can be dangerous and risky...Guys are going to try to take advantage of that...especially if they know you’re on it because they think that you wanna have sex ...” (Eiserman, Diamond & Schmenseul, 2008, p.31). The perception that a heightened sexual desire entails consent to sex may also explain why some men encouraged women to consume drugs when disparities in sexual desire occurred, “He say, “Come on, this gonna make your sex drive better.” I say, “All right, come on” (El-bassell, Gilbert & Rajah, 2003, p.1393).

A discussion surrounding women and MSM who used drugs and were perceived to, or did, exchange them for sex was not uncommon (Bourne et al., 2014; Jerome, Halkitis & Siconolfi, 2009; Jessell et al., 2017; Liu & Chai, 2018; Palamar et al., 2014; Skårner & Svensson, 2013). Offering drugs to peers represented a way for (predominantly) men to obtain sex from women or other men that would not otherwise have had sex with them (Jerome, Halkitis & Siconolfi, 2009; Jessell et al., 2017; Palamar et al., 2014). One gay man reported that, “Guys will get boys really high on cocaine in order to get them into bed...” (Palamar et al., 2014; p.154). Providing drugs to another person was assumed to entail sexual “favours” in return. This expectation may be strengthened according to who the potential

drug recipient is. For example, in one study, gay and bisexual men who were perceived as ‘sexually appealing’ reported being more likely to be offered drugs (Bourne et al., 2014). Another study found that 57% of opiate consumers had been offered drugs or money (primarily by men) in exchange for sex because they were perceived to be ‘addicted’ (Jessell et al., 2017). Whilst commercial sex (i.e., sex work) was reported, implicit or transactional sex (e.g., sharing drugs or providing drugs free of cost) was most common. Skårner & Svensson (2013) noted that “no one described having exchanged sex for drugs in any kind of direct transaction” (p.409). When sexual exchanges do take place, beliefs surrounding reciprocity are likely reinforced.

When drug-taking is a shared activity rather than being seen to be ‘owed’, or when individuals feel empowered to negotiate consent in the first instance, people likely experience short- and long-term benefits associated with exchanging sex and drugs. This may be because people have (or perceived themselves to have) agency surrounding their choice(s). However, normative expectations surrounding sexual exchange could delimit autonomy. Specifically, when there is an expectation that providing drugs should lead to a sexual experience, the recipient may feel a lack of freedom to give non-consent, that is, say no, “Eventually it’s going to lead to sex ... I guess you feel like you have to, especially for a female...” (Jessell et al., 2017, p.10). The authors of one study concluded that gendered hierarchies continue to prevail in drug subcultures because many men are in a position of power over drug-consuming women, “An underlying thought in the reasoning around “speed whores” [a term used to refer to women who will, or are perceived to be willing to, exchange sex for drugs] is that male dominance is upheld and strengthened, for men are in control of the procurement of drugs” (Skårner & Svensson, 2013, p.409).

Drug-taking can diminish the Capacity to make Sexual Decisions

Some participants reported that drug-taking bore no impact on their sexual decision-making (Kennedy, Grov & Parsons, 2010; Palamar et al., 2018; Pass et al., 2015). For example, some people felt they were no more likely to consent to sex that was “risky” or out of the norm for them, “I don’t think being high has ever made me more likely to do anything I consider risky” (Palamar et al., 2018, p.766). At lower-levels of drug-intoxication, people likely have the cognitive capabilities to make decisions similar to those that would be made sober (Parrot, 2003). Cognitive capacity was evidenced by people’s ability to assess risk and take precautionary measures including to sexual health practices, “...I said, ‘No, no condom, you cannot have this [pointing to his asshole]’ He then picked up the condom reluctantly, and, I put it on...” (Lim et al., 2018, p.259). Cognitive capacity was also demonstrated through an awareness of the consequences of actions, “...there were moments where I was thinking in the sober corner of my mind, you are going to regret this” (Kennedy, Grov & Parsons, 2010, p.162).

In almost one-fifth of the articles, drug-taking was discussed to improve decision-making / clarity of thought. This was sometimes in contrast with alcohol consumption, as described by this participant, “I’d say you have more control on E than if were pissed [intoxicated]. I think you’re much more conscious of what you’re doing” (McElrath, 2005, p.1472); however, it could also be more generally, “I find when I smoke cannabis I wish I had a Dictaphone because my thinking processes tend to become very clear. It’s like instant wisdom” (Palamar et al., 2018, p.766). One participant noted that the perception of clarity, rather than actual clarity, could be an effect of drug-taking.

In contrast to an ‘improved’ or lack of effect on sexual decision-making, an impaired or altered judgement (e.g., poorer treatment of a sexual partner, being less able to effectively judge risk, benefit, or consequence) was more commonly described by participants. This perceived impairment in judgement was evidenced by one participant who described feeling

retrospectively concerned about his drug-involved sexual behavior. It was this retrospective ‘concern’ surrounding his behavior which suggested that he was not making decisions during drug-involved sex that were in line with what he would otherwise consider to be ‘acceptable’, “Admittedly it’s cold and disconnected to the point where I forget I have another human being in my hands as opposed to a sex toy...upon reflection it’s quite disturbing” (Van Hout & Brennan, 2011, p.98). Impaired judgement was often described to result from the sexual effects of drugs, notably, methamphetamine, GHB and mephedrone (Bourne et al., 2014; Van Hout & Brennan, 2011; Deimel et al., 2016; Green & Halkitis, 2006; Lim et al., 2018; Baumeister, 2007; Mullen et al., 2009). Primarily men (although not exclusively), described impaired sexual decision-making to be a result of having a preoccupation with orgasm during drug-involved sex (Bourne et al., 2014; Van Hout & Brennan, 2011; Green & Halkitis, 2006; Liu & Chai, 2018). Orgasm is often seen to be the ‘marker’ of the end of sex, therefore, some individuals may feel that their ‘goal’ has not been reached until they climax (Opperman, Braun, Clarke & Rogers, 2014). This is likely pertinent to men, whose orgasm is often considered the end of a sexual encounter, “I’m like, “Yo, I done come!” I done came and he still want to keep going” (El-bassell, Gilbert & Rajah, 2003; p.1391). This focus on orgasm also resulted in some people describing behavior taking place that they might not have otherwise engaged in, such as condomless sex with someone whose health status was unknown, “It’s like a, oh, I’m gonna get this orgasm and that’s all that matters. I’m not thinking about what I could catch” (McElrath, 2005, p.390).

People also experienced a partial or complete unawareness of what was happening, which disabled them from making informed decisions (Bourne et al., 2014; Deimel et al., 2016; Liu & Chai., 2018; Palamar et al., 2014), “I’m like, ‘Who the hell is this?’ If I become coherent, then I’ll stop. But there are times when I’m just so fucked up where I’m just like, ‘Okay, whatever’...” (Palamar et al., 2014, p.151). At higher intoxication levels, irrespective

of whether consent was verbally communicated, or what that decision would have been otherwise, people may lack capacity to make sexual decisions in the first instance. Two studies highlighted the ‘problems’ with conceptualizations of capacity to consent in drug-taking contexts (Bourne et al., 2014; Harvey, Hayton, Beard & Holly, 2013). One participant in Bourne et al.’s (2014) Chemsex study stated, “If someone had had too much and their inhibitions are reduced and none of it is really consensual, but then none of it is against anyone’s will... Some people are giving consent but I mean is it really consent when someone is literally on the verge of passing out?” (p.59). This extract highlights how an individual might be ‘consenting’ but also experiencing the effects of drugs that prevent that consent from being meaningful. When prevailing models of consent are drawn upon, such as those that prioritize communicative consent, it is possible that some people feel justified in having sex with a person displaying diminished capacity if they ‘say yes’.

As well as impacting decision-making, drug-taking also affected how ‘suggestable’ people were and this appeared to increase the likelihood of people consenting to sex (McElrath, 2005; O’Byrne & Holmes, 2011; Eiserman, Diamond & Schmensusl, 2008; Mullens et al., 2009). Less time was spent weighing the pros and cons of decision-making during higher levels of intoxication, “...you certainly don’t hold back. You don’t – I don’t have that moment of thinking, “Ooh, should I? Shouldn’t I?” (Bourne et al., 2014, p.54). This effect may increase the ease of gaining sexual consent from a person who has consumed drugs, “There doesn’t seem to be a whole lot of hesitation about much. If he asks me to do something then certainly I would do it” (Palamar et al., 2014, p.155). One woman’s quote alluded to the idea that being high could lead to greater acceptance of sexual advances, “People [have]...start[ed] doing stuff that you would never think that they would do...they come up to you and kiss you without even knowing you, or start touching you. But you[’re] so high, that you go with the flow...” (Eiserman, Diamond & Schmensusl, 2008, p.20).

However, the authors did not indicate the extent to which she considered this experience retrospectively to be consensual.

During periods of diminished capacity, the likelihood of sexual exploitation may be heightened due to the negative beliefs that people hold about heavily intoxicated people. For example, that they do not ‘deserve’ a ‘choice’ surrounding their sexual engagement. One woman stated, “There’s guys that will know that these girls...have no idea what they’re doing. And they’re like, “I’m gonna hook up with her anyway”—and they end up having sex with them... this girl’s a fucking dumb bitch. Like she’s a whore, like she doesn’t know what she’s doing.” (Jessell et al., 2017, p.13). Exploitative sexual behavior was sometimes justified and normalized through ‘just world’ narratives (El-bassell, Gilbert & Rajah, 2003; Jessell et al., 2017; Skårner & Svensson, 2013). One male participant stated, “All you gotta do is wave the bag around.... It’s tragic, but that’s how it is...Unfortunately, that’s reality, and I didn’t like exploiting it, but you do...” (Skårner & Svensson, 2013, p.409). In relation to ‘having sex’ with people experiencing reduced capacity in Chemsex settings, one man noted, “This is normal! Nobody’s sort of horrified, shocked and who knows what was happening to him when he was like that, people could stick it in and do what they like” (Bourne et al., 2014, p.61).

Drug-taking reduces Verbal and Non-Verbal Ability to Communicate Consent

None of the papers had a primary focus on the particulars of consent communication, however, some participant quotes demonstrated how consent was communicated during sex on drugs. For example, one man described using direct verbal communication strategies to initiate sex, “I’m gonna bump K (ketamine) and then you can fuck me, okay?” (Palamar et al., 2014, p.152). In the short period of time prior to experiencing the effects of drugs, individuals are likely able to communicate and negotiate their consent. As the drug effects

reach their peak, the ability to communicate may diminish. One woman reported that being high had sometimes led to the inability to speak out/resist sexual acts (Palamar et al., 2018). This was presumably due to an increased level of incapacitation; however, the context of this incident was unclear. Thus, drug-taking appears to affect the ability to verbally communicate, irrespective of what that decision would have been, "...verbally, I can't interact with others...null and void" (Mullens et al., 2009, p.144).

Bourne et al., (2014) reported that loss of consciousness was not uncommon during Chemsex scenes. Furthermore, people described experiencing a loss of motor functioning that might be needed to communicate consent non-verbally (Bourne et al., 2014; Deimel et al., 2016; Palamar et al., 2018; Palamar et al., 2014; Mullens et al., 2014). For example, one participant said, "Passive. Actually just passive. You know, [no] longer really know what your body is doing. You totally lose all of your functions. And that actually wasn't all that pleasant" (Deimel et al., 2016, p.6). One participant also described sex as more 'instinctual' following drug-taking because of a loss in communicative abilities, "When people are on G (GHB) it's like their communication centre shuts down and it's very much instinctual..." (Bourne et al., 2014, p.46). In some instances, incapacitation appeared to be an unplanned outcome of drug-taking prior to sex. Where engaging in sexual contact with someone who is incapacitated is normalized, such as, by others in society or those involved with the Chemsex scene, it is possible that a subculture of 'consent norms' are created that have the potential to cause harm. However, we must also recognize that, for some people, total incapacitation could be a desired outcome of their sexualized drug-taking (e.g., to achieve powerlessness). Thus, some people may not perceive these experiences in a negative light, "First, I no longer have control over my body and my partner. I just don't care about what happens to me. I just let myself experience the feeling..." (Deimel et al., 2016, p.7).

Discussion

The aims of this review were to examine the research on people's attitudes towards and experiences of sexual consent during drug-involved consensual sex. The specific areas focused upon were a person's freedom and capacity to give/gain sexual consent, their feelings of willingness to have sex and the particulars of consent communication during drug-involved sex. The following section provides a summary of the key findings from the thematic synthesis and discusses how those findings relate to or extend prior research. Implications for theory and practice are also discussed.

Freedom to Consent to Sex

Several studies discussed how drug-taking could result in a (perceived) increase in sexual autonomy; individuals reported feeling willing to engage in sexual acts that they otherwise could or would not and have sex with people that they might not otherwise. Drugs appeared to facilitate the engagement in these sexual practices due to their disinhibiting properties. They appeared to remove concerns surrounding others' perceptions of their engagement in the sexual act, self-esteem (e.g., body image), or the sexual act itself (e.g., that it might be painful). Two studies of men who have sex with men also described how drug-taking, whilst increasing freedom, could also serve an excusatory role. That is, drugs could be afforded 'blame' when there was a concern that their sexual behavior would be judged negatively by others.

One of the important points to highlight in the context of these findings is that much of this research was undertaken with groups who experience greater policing of their sexuality in society. Historically, gay and bisexual men have had their sexual practices aligned with 'risk', 'danger' and 'deviance', for example, by the media, the law, and medicine. Contemporary Chemsex narratives typically depict gay and bisexual men in this way (i.e., as risk-taking and 'deviant'; Hickson, 2018). Stories of sexual pleasure have not

been visible for this group of men at a wider societal level (although recent research has made an effort to discuss experiences of pleasure; e.g., Milhet, Shah, Madesclair & Gaissad, 2019). Similarly, heterosexual women's sexual desire is not at the forefront of public discourse surrounding women's sexuality. Instead, women's sexuality is more often discussed in relation to 'risk'. For example, of unwanted pregnancy and sexual exploitation. This means that often, they are positioned as the passive 'sexual gatekeeper', rather than as active pursuers of sexual pleasure (Allen, 2013). Given how both women and gay and bisexual men's sexuality has been constructed by society, it is unsurprising that some reported that they consumed drugs to alleviate concerns that prevented engagement in desired sex. To reduce the extent to which people feel drugs are necessary to engage in desired sex, we must challenge societal attitudes that delimit people's agency and power in the first place. The findings from this review suggest these include attitudes relating to gender, sexuality, body-image ideals and what constitutes 'typical' vs. 'atypical' sex.

Sexual norms surrounding the sexual availability of people who consume drugs can negatively impact their sexual autonomy. Across several articles, there was the belief that the acute use of drugs increased sexual desire; something that has been noted in earlier work on the subjective sex effects of drug-taking (Sumnall, Beynon, Conchie & Cole, 2007). This belief could result in the problematic belief of others as being 'up for sex' when they were consuming drugs. In some instances, this resulted in scenarios whereby people felt 'at-risk' of others' sexual advances following drug-taking. That is, irrespective of whether they were willing, some people were not, or felt that they would not be given, the opportunity to communicate it. A similar relationship for alcohol and sexual consent has been found, such that men perceive women drinkers as wanting/desiring sex and view their drinking behavior as a consent cue (Jozkowski, Manning and Hunt, 2018).

Sexual wanting and sexual consent are often used interchangeably, for example, in the media, education, and sometimes within academic research (Fischel, 2019). Given that these terms are used interchangeably across the social ecology, it is possible that people perceive the terms as synonymous. Cues associated with sexual wanting or desire may be used to determine the presence of consent in place of those related to willingness. When people perceive others as ‘wanting’ sex, such as when they hold the belief that alcohol or drugs increase sexual desire, they may feel entitled to forego practices that would determine whether the person is willing. Given the limited number of studies included in this review, future research would benefit from exploring whether ‘sexual availability’ is seen to be heightened across all illicit drugs or whether some drugs, or drugs in particular contexts, have stronger associations with this misconception. This information would be beneficial to harm-reduction and prevention material which focused on deconstructing misconceptions about substance use, sexual desire, and sexual consent.

‘Sexual exchanges’ were a salient topic in this review. That is, people held beliefs that drugs would be exchanged for sex and both women, and men who had sex with other men, reported that they had engaged in sex and drug exchanges as recipients (i.e., of drugs); men were commonly the drug ‘providers’ (i.e., providing drugs to others). As opposed to engaging in ‘explicit’ exchanges, such as sex work / commercial sex, most of these exchanges were described as happening implicitly. Thus, unlike in sex work contexts in which negotiations are - or at least should be - explicitly discussed by the people engaged in the sexual activity, people may rely on the wider social norms and scripts to guide behavior.

For some individuals, implicit exchanges are not likely to be associated with future negative outcomes, such as in instances where people have been able to negotiate their sexual boundaries, refuse sex or offer an alternative way to obtain drugs (i.e., such as monetary payment) and where there are no negative consequence to saying ‘no’ (Tambe, 2018).

However, the idea that drugs and sex should be exchanged, could limit people's perceived or actual sexual freedoms. Women described feeling as though they 'had to' have sex with men who had given them drugs for 'free'. It is possible that 'quid pro quo' or reciprocity norms are drawn upon in these contexts and that these reduce the freedom to give non-consent specifically. Furthermore, if sex is seen as 'owed' then any degree of persuasion, coercion or violence may feel justifiable; gendered norms likely converge with those surrounding sexual reciprocity to limit women's freedoms specifically. Women describe, both in this review and elsewhere, the pressures that women face to sexually please their male partners. This may be the result of common discourses such as 'the biological imperative' which present men as having strong sex drives that need satisfying (Potts, 2002).

Capacity to Make Sexual Decisions

Many policymakers, educators and activists position affirmative consent as the 'gold-star' standard (Jozkowski, 2015). However, the data from this thematic synthesis suggest a need to go beyond the discussion of affirmative consent to identify what it means to have the capacity to make sexual decisions. Drawing upon the mental health and medical field may be beneficial when devising educational programmes and materials, as it sets out greater guidance for assessing a person's capacity to consent. Using the Mental Capacity Act (2005) as a starting point, we may consider a model of consent that first encourages people to assess whether sexual partners are able to: retain information over extended periods of time (e.g., health-status, whether a condom is being used), weigh up the pros and cons of a decision (e.g., benefits and harms of engaging in this particular sex at this particular time), appreciate the likely consequences of a decision (e.g., emotional, relational, physical), as well as make and communicate decisions. In this review, drug-taking was found to impact each of these areas to varying degrees. For example, they increased suggestibility, increased and decreased clarity of thought and could result in an inability to remain aware during sexual encounters or

remember what took place after the event. Drug-taking also resulted in a reduced ability to assess sexual health-related risks and/or consider the potential consequences of actions.

Outlining these drug-related effects to people who might in the future (e.g., young people), or those who already do, engage in drug-taking, is an important area of harm-reduction. Education messages may need to highlight the importance of spending non-sexual time with potential sexual partners to assess individual areas of capacity. Individuals will likely vary in the extent to which they are able to do this irrespective of whether they are high or not. However, by encouraging people to reflect on these criteria (e.g., can they engage in a conversation?) we may increase the degree to which they feel they are able to determine whether their partner has the capacity to make meaningful sexual decisions.

Applied to legal settings, individuals would be required to demonstrate the reasonable steps taken towards ensuring that their partner had the capacity to consent, followed by the steps taken to determine their partner's willingness to participate (i.e., through verbal or non-verbal means). Currently in the United Kingdom, determining whether a person had the capacity to give consent following alcohol or drug-taking remains largely dependent on the understanding and attitudes of jurors (see Sexual Offences Act, 2003). Education surrounding capacity to make decisions and drug-taking would likely reduce victim-blaming attitudes (e.g., that women put themselves at risk of sexual violence when they consume substances) amongst jurors.

Powers and Leili (2016) found that a lack of knowledge and education surrounding sexual consent and alcohol intoxication has prevented individuals who work in the bar industry from feeling able to intervene in sexual harassment scenarios (i.e., because they did not know what legally constituted being "too drunk" to have sex). Therefore, information on capacity to make sexual decisions in the context of drug-taking would likely be beneficial to

future education initiatives, such as bystander prevention programmes, targeting bar/club staff, sex-on-premises venue staff, or Chemsex party organizers / attendees. These people have the potential to implement policies and prevention messages within spaces that are often both sexualized and associated with substance use. They may also be able to intervene in situations in which one or both people appear to be under the influence of drugs and may not have the capacity to consent or in which a person is perhaps being taken advantage of by another person on premises. However, with many nightlife venues having ‘zero-tolerance’ policies surrounding drug use, it may be difficult to implement training without being seen as legitimizing drug-taking in the first instance. There may also be other factors that would prevent individuals from intervening regardless of their knowledge surrounding capacity to consent. For example, perceived social concerns or embarrassment associated with intervention (Burn, 2009). This suggests that knowledge-building surrounding capacity to consent would likely benefit from taking place concurrently with wider initiatives that aim to increase positive peer norms surrounding sexual consent.

Ability to Communicate Consent

Finally, the included papers lacked a focus on the particulars of consent communication, meaning that very limited conclusions can be drawn in relation to this review aim. The conclusions primarily spoke to the ability to communicate rather than specific tactics used. People showed the ability to communicate using verbal communication methods; however, drugs sometimes resulted in a loss of motor function that could reduce the ability to communicate non/verbally. Future research should examine the sexual consent communication strategies that are employed by individuals in drug-taking settings and how these are different or similar compared to sober ones. Both qualitative and quantitative research in this area would be informative, and in the case of the latter, existing psychometric

measures are available (e.g., The Dual Measures of Consent Scale; Jozkowski, Sanders, Peterson, Dennis & Reece, 2014).

It is important that we think carefully about how consent should or could be communicated during drug-taking scenarios where individuals experience a loss (or there is potential for loss) of the ability to communicate. For example, for some people total passivity may only be perceived as obtainable through drug-taking. Where this is the desired outcome, we must think carefully about how to ensure that individuals are not being taken advantage of whilst also ensuring that sexual consent messages do not increase levels of shame or blame for these individuals. It is possible that situational factors such as who the sexual partner(s) is/are, and the engagement in practices such as pre- and post- sexual discussions surrounding sexual boundaries, could reduce the likelihood of harm (Faccio, Casini & Cipolletta, 2014).

Limitations of Included Studies

Whilst in some contexts (e.g., Chemsex) it is likely that all individuals engaging in sex are consuming drugs, none of the studies explicitly addressed couple or multi-person vs. single person drug-taking and the impact that this had on sexual consent. This is likely because, in most studies, sexual consent was a secondary focus or only covered incidentally in the participant extracts that the authors chose to include. No study explicitly discussed how sexual partners communicated consent during drug-involved sex. Instead, whilst they met the inclusion/exclusion for this review, they focused on the broader sexual effects of drugs on sexual desire or physiology, the sexual effects of drugs over the course of addiction, or experiences of sexual violence. To develop evidence-informed prevention campaigns or interventions that reduce harms associated with using drugs in sexual contexts and increase people's sexual safety and pleasure, we must understand what sexual consent in the context

of drug-taking looks like to those engaged in it. This includes understanding how the number of people consuming drugs at the time influences how consent is navigated.

Participants drew upon their experiences of having sex on specific drugs or specific sets of drugs. However, in some instances it was clear that participants had consumed alcohol concurrently with those drugs. In these instances, it becomes difficult to disentangle the effects of alcohol from other drugs on sexual consent. Future research would benefit from focusing solely on ‘other drugs’ either in comparison to alcohol or in their own right.

There was a tendency for researchers to address people’s sexual experiences on drugs more broadly as opposed to asking about the experiences at the level of the event (e.g., asking participants to discuss the effects of “club drugs” on sexual behavior). Whilst this is an important knowledge base and provides us with more general understandings of drug-involved sex, event-level approaches, that ask people to report about specific occasions (e.g., most recent sexual experience on drugs) would result in a more thorough understanding of behavior (LaBrie, Hummer, Ghaidarov, Lac & Kenney, 2014).

Almost half of the articles exclusively sampled men who have sex with men and the representation of experiences and attitudes for other groups was low. There is evidence that some lesbian, bisexual or queer+ women use drugs during sex (Mooney-Somers, Deacon, Klinner, Richters & Parkhill, 2017), however, no article exclusively addressed sexual consent for these groups. Where women who had sex with women were sampled, the findings were not separated from women who did not have sex with women during the analysis. In order to construct tailored educational material about drug-taking and sexual experiences that accounts for the differences and similarities between different groups, we must consider heterosexual and lesbian, gay, bisexual, queer+ people’s experiences, respectively. Without

addressing these gaps, we cannot ascertain whether there are unique drug- and sexual consent- related considerations for subgroups of the population.

In comparison to published literature, both unpublished reports (Bourne et al., 2014; Harvey, Hayton, Holly & Beard, 2013) lacked sufficient detail and justification for the methods used, such as the steps taken during data analysis. Furthermore, most studies did not adequately discuss the researcher's influence on the data in an explicit way; for example, how their own positions might have influenced the design, data collection and analysis process. Given that our individual worldviews and experiences can impact the interpretations of our data (Maxwell, 2012), researchers should reflect on how they have impacted upon the knowledge produced from their research. With this in mind, we recognize that our social positioning has likely affected on the interpretations of the primary data. For example, over half of the sample for this review constituted men who have sex with men. Therefore, our position as heterosexual or queer women academics may have led to different understandings of these data than men who have sex with men.

Strengths and Limitations of the Review

As the researchers' native language was English, only papers published in the English were included; relevant non-English papers and research published in other languages by non-western researchers may have been overlooked. The effect of this was perhaps mitigated by the primary author searching the reference lists of included papers (Gagnon et al., 2012). In a review of sexualities literature carried out in non-western / Global South countries, no included article was categorized as having a main focus of sexual consent (Dworkin, Lerum & Zakaras, 2015). This increases confidence that all relevant literature with sexual consent as a primary focus was sought. As many of the articles were determined to meet the inclusion criteria based on full-text reading, some articles with relevant findings (i.e., as a secondary/

incidental focus) may have been overlooked during the title and abstract screening stage. Whilst this is a possible limitation, it also highlights the necessity for researchers to focus more explicitly on issues pertaining to sexual consent.

Conclusions

Sexual consent was not the prominent focus of research on sexual experiences and drug-taking, meaning that an in-depth analysis of issues pertaining to consent were absent from the articles. Despite this, based on a thematic synthesis of relevant findings from 21 articles, three themes were constructed and discussed. Our review suggests that taking account of both individual level factors (e.g., gender, sexual orientation) and the broader context in which consent is determined (i.e., the immediate situational context in which sex takes place and the wider social structures that people are embedded in), will enable us to identify how, where, and when people's sexual choices are limited/extended. Furthermore, we propose that current models of affirmative consent do not account for circumstances related to drug-involved sex, such as when consent was given, but where freedom or capacity was limited. Drawing on broader frameworks of informed consent, such as those used in the medical field, may allow us to better understand how drug-taking affects an individual's capacity to consent. This has theoretical, educational and legislative implications which have been discussed. Lastly, a lack of research surrounding the particulars of sexual consent communication following drug-use highlights a need for work in this area.

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